

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

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2. STATE:

MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL
SECURITY ACT (MEDICAID)

Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

October 1, 1996

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 447.250-299

7. FEDERAL BUDGET IMPACT:

a. FFY 97 \$ 850,000b. FFY 98 \$ 850,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

ATTACHMENT 4.19 -A (2a.)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):

SAME

10. SUBJECT OF AMENDMENT:

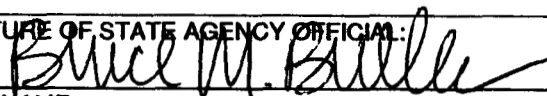
Non-State Owned Chronic and Rehabilitation Hospitals

GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL☒ OTHER, AS SPECIFIED:

Not required under 42 CFR 204.1

12. SIGNATURE OF STATE AGENCY OFFICIAL:



13. TYPED NAME:

Bruce M. Bullen

14. TITLE:

Commissioner

15. DATE SUBMITTED:

December 27, 1996

16. RETURN TO:

Bridget Landers
State Plan Coordinator
Division of Medical Assistance
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Boston, MA 02111

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

December 30, 1996

18. DATE APPROVED:

May 4, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

October 1, 1996

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

Ronald P. Preston

22. TITLE:

ARA, DMSO, Boston Region

23. REMARKS:

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State Plan Under Title XIX of the Social Security Act
Massachusetts Medical Assistance Program

**Methods Used to Determine Rates of Payment
for Non-State-Owned Chronic/Rehabilitation Hospital Services**

I. GENERAL DESCRIPTION OF PAYMENT METHODOLOGY

Nonacute hospitals participating in the Massachusetts Medical Assistance Program include non-State-Owned Chronic/Rehabilitation Hospitals.

The basic payment methodology described in this attachment was effective October 1, 1996. Chronic/Rehabilitation Hospitals are governed by 114.1 CMR 39.00, the regulation that implements this methodology. Changes are now proposed in response to passage of M.G.L. c. 118E, s. 13A and M.G.L. c. 118G. These provisions do not apply, however, to ICF/MRs having more than 15 beds, which are reimbursed under 114.1 CMR 29.00, or to State-Owned Nonacute Hospitals and psychiatric hospitals which are now governed by 114.1 CMR 40.00.

I.A. The following is a general description of the chief components of the new payment method for non-State-Owned Chronic/Rehabilitation Hospital services.

1. The former charge-based method of reimbursing inpatient services on a per-service basis is no longer employed. The new method establishes a comprehensive Inpatient Per Diem Rate which covers both routine services and ancillary services provided to inpatients. The Inpatient Per Diem Rate shall not exceed the hospital's average charge per day.
2. Each hospital's specific Inpatient Per Diem Rate is calculated by dividing the sum of the hospital's Allowable Base Year Inpatient Operating costs, adjusted to reflect appropriate cost increases or decreases since the base year resulting from substantial program changes and inflation, plus the hospital's Allowable Inpatient Capital divided by the hospital's Base Year Patient Days.
3. For non-State-Owned Nonacute Hospitals licensed and operated as Chronic/Rehabilitation Hospitals in FY 1993, Allowable Costs are determined from a base year that has been fixed at FY 1993. Special base year provisions apply to new non-State-Owned Chronic/Rehabilitation Hospitals as well as to non-State-Owned Chronic/Rehabilitation Hospitals which closed a majority of beds and provide some services in a new location under new

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management.

4. Individual efficiency standards are applied to Inpatient Overhead Costs, Inpatient Capital Costs and six (6) Inpatient Direct Ancillary costs: laboratory, radiology, speech therapy, physical therapy, occupational therapy, and respiratory therapy.
5. Outpatient services are reimbursed on a per-service basis, using a cost-to-charge ratio for each hospital, derived from the hospital's Base Year Outpatient Costs and Base Year Charges.

I.B. The following describes the changes made to implement various provisions of Chapter 270 of the Acts of 1988.

1. The Commonwealth will establish a separate per-diem rate of \$113.27 for inpatient services furnished to administrative day patients.
2. The Commonwealth will adjust rates of payment to compensate non-State-Owned Chronic/Rehabilitation Hospitals for cost increases related to recruiting and retaining direct-care labor. Rates will be adjusted in two ways: 1) the inflation adjustment used to derive the rate year operating costs will be increased to reflect the increased costs of direct care personnel in the Commonwealth; and 2) hospitals which can demonstrate extraordinary cost increases for direct care personnel, in excess of the amount allowed through inflation, will receive an adjustment.
3. A non-State-Owned Chronic/Rehabilitation hospital will receive a supplementary payment for its hospital level of payments to ensure that payments for services to publicly assisted patients meet total reasonable hospital costs.

I.C. Patients Transferred from State Facilities

The following describes the payment method for non-State-Owned Chronic/Rehabilitation Hospital services provided to former patients of Lakeville Hospital, a State-Owned Nonacute Hospital which has been closed.

The rate of payment in connection with this state facility closure has been set based on allowable actual costs under the methodology described herein and expenses which must be incurred by a provider in order to serve the particular patients transferred from this state facility. The Division of Health Care Finance and Policy (DHCFP) reviewed the budget costs of

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the hospital, to which patients were to be transferred, and found them to meet the reasonableness standards of the rate methodology of the Division of Health Care Finance and Policy (DHCFP). Pursuant to such rate setting, the provider must demonstrate that items and services, furnished because of the special needs of the patients transferred, are necessary in the efficient delivery of necessary health care.

I.D. Managed Care for Non-State-Owned Chronic/Rehabilitation Hospitals

The department has established a contractual managed-care program with non-State-Owned Chronic/Rehabilitation Hospitals. Contractually, this program is established through the addition of special conditions to the standard Medicaid Provider Agreement. The intent of the program is to allow hospitals an opportunity to provide management of the delivery of all Medicaid covered medical services and care needed by the recipient while an inpatient at the hospital. Contracted hospitals will have the responsibility to provide or arrange and pay for all Medicaid covered medical services, except acute inpatient hospital services. Providers with a managed-care program agreement must continue to comply with all applicable laws and regulations, including 42 CFR 431.51, the recipient free choice of provider right.

The following describes the payment methodology for non-State-Owned Chronic/Rehabilitation Hospitals which enter into an agreement with the Division of Medical Assistance (DMA) to offer a managed care program for inpatients and/or outpatients in a facility. To receive such payment, a non-State-Owned Chronic/ Rehabilitation Hospital must agree, by contract with the Division of Medical Assistance (DMA), to one of the conditions below.

1. provide or arrange for all Medicaid covered services, except acute in-patient hospital services, to all Medicaid recipients who are inpatients of the chronic hospital. The per diem rate shall not exceed the sum of (a) the lowest per diem amount paid by the Medical Assistance Program to a chronic hospital for inpatient care, (b) the average per diem amount paid by the Medical Assistance Program for all other Medicaid services provided to recipients in such chronic hospital, (c) the average per diem Medicare co-pay and deductible paid by the Medical Assistance Program on behalf of such recipients, and (d) additional costs incurred by the chronic hospital for (i) offering services on-site which usually are provided only off-site, (ii) providing case management services to recipients awaiting admission to the chronic hospital and (iii) developing any innovative community

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long-term care models to which the Division of Medical Assistance (DMA) agrees. Actual payment to the chronic hospital shall be the contracted monthly per diem rate as so described, less any patient paid amounts and or any third party payments. Where the per diem rate does not include the average Medicare co-pay and deductible stated in subsection (c), the facility may separately bill and receive from the Division of Medical Assistance (DMA) an amount equal to the Medicare co-pay and deductible.

2. provide for certain services to disabled children in a specialty non-acute pediatric hospital. The hospital may provide for both the inpatient and outpatient medical, surgical and dental needs for disabled infants and children. In addition, the hospital will be responsible for the coordination of care with other health care providers and appropriate state and local agencies.

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Reimbursement will be based upon a per diem rate for inpatient services and a per visit rate for outpatient services. The methodology to establish the separate rates will be the following:

Inpatient Per-Diem = Annual Budget x Percentage of Annual
Budget for inpatient services

Prior FY actual Medicaid patient days

Outpatient Per-Visit = Annual Budget x Percentage of Annual
Budget for Outpatient Services

Prior FY actual Medicaid outpatient visits

Actual payment to the non-acute pediatric hospital shall be the contracted per diem and per visit rate as established above paid on a weekly basis. A total of all payments made in the preceding quarter will be determined by the Division of Medical Assistance (DMA). If payment to the hospital in the preceding quarter exceeds the Quarterly Budget by 10%, the hospital must return the difference between the amount of actual payments made for the quarter and the Quarterly Budget amount. If payment to the hospital for the preceding quarter is below the hospital's Quarterly Budget by 10%, the Division of Medical Assistance (DMA) will, for the first two quarters only, reimburse the hospital the difference between the amount of actual payments made for the quarter and up to 10% of the Quarterly Budget amount.

II. **DEFINITIONS**

Administrative Day (AD). An inpatient day spent in a hospital by a patient who has been identified by a Peer Review Organization (where applicable) or otherwise by the Division of Medical Assistance (DMA) or by the Department of Public Health (DPH), or any combination of these organizations as a patient not requiring hospital level of Care.

Base Year. (1) For hospitals licensed and/or operated as non-State-Owned Chronic/ Rehabilitation Hospitals in Fiscal Year 1993 (FY 1993), the base year is the hospital's FY 1993. (2) For hospitals licensed and/or operated as non-State-Owned Chronic/Rehabilitation Hospitals in FY 1993 but which converted a majority of beds to long term care beds during FY 1993, the base year shall be FY 1994 deflated to FY 1993. (3) For hospitals licensed and/or operated as non-State-Owned Chronic/Rehabilitation Hospitals in FY 1993, but which eliminated a majority of beds and closed the facility and which in subsequent years continued to provide some services in a new location under

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a new management, the base year is the first cost reporting period of at least twelve months after the hospital started to provide the service at the new location. (4) For hospitals which were not licensed and/or operated as non-State-Owned Chronic/Rehabilitation Hospitals in FY 1993, the base year is the first cost reporting period of at least twelve months after the hospital is licensed and/or operated as a non-State-Owned Chronic/Rehabilitation Hospital.

DPH. The Department of Public Health established under M.G.L. c. 17, s. 1.

Direct Cost. The patient care costs of a cost center exclusive of overhead and capital.

DHCFP. The Division of Health Care Finance and Policy established under M.G.L. c. 118G, formerly the Rate Setting Commission.

DMA. The Division of Medical Assistance established under M.G.L. c. 118E.

FTEs. FTE is an acronym for full-time equivalent staff. To compute full-time equivalents (FTE's), divide the total annual paid hours (including vacation, sick leave, and overtime) for all employees in each cost center by a forty (40) hour work week, annualized to a norm of 2080 hours.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, or political subdivision of the Commonwealth.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual, promulgated by the DHCFP under 114.1 CMR 4.00.

New Hospital. A hospital which is not licensed and/or operated as non-State-Owned Chronic/Rehabilitation Hospital in FY 1993 or which did not report a full year of actual costs in FY 1993.

Nonacute Hospital. A hospital that is defined and licensed under M.G.L. c. 111, s. 51, with less than a majority of medical-surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, s. 29.

Overhead. Overhead consists of expenses for fringe benefits, administration, plant maintenance and repairs, plant operations, laundry, housekeeping, cafeteria, dietary, maintenance personnel, nursing administration and in-service education, RN & LPN education, medical staff teaching and administration, post graduate medical education, central service and supplies, pharmacy, medical records, medical care review, and social services.

Publicly Aided Individual. A person who received health care and services for which a governmental unit is in whole or part liable under a statutory program of

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public assistance.

State-Owned Nonacute Hospital. A hospital that is operated by the Massachusetts Department of Public Health (DPH) with less than a majority of medical- surgical, pediatric, maternity, and obstetric beds , or any psychiatric facility operated by the Department of Mental Health (DMH).

Transfer of Costs. An increase (transfer on) or decrease (transfer off) of hospital costs related to persons or entities that provide hospital care or services, and which change compensation arrangements from non-hospital based to hospital based (transfer on) or from hospital based to non-hospital based (transfer off). A transfer on of physician compensation will only be allowed if reasonable.

III. MEDICAID PAYMENT METHODOLOGY FOR NON-STATE-OWNED CHRONIC/REHABILITATION HOSPITALS

For any particular year, a provider-specific Medicaid rate will be calculated. The inpatient rate is derived from the Allowable Base Year Costs divided by Base Year Patient Days.

III.A. Determination of the Inpatient Rate

Except for new hospitals and hospitals which have closed the facility and now provide some services at a new location under new management, the methods to determine the Inpatient Rate for non-Administrative Day Patients is set forth below. The methods to determine the Inpatient Rate for new hospitals and hospitals which have closed the facility and now provide some services at a new location is set forth in Section III. A. 6. The method of payment for services provided to Administrative Day Patients is set forth in Section III. A. 7.

1. Data Sources: The Base Year for Allowable Inpatient Costs will be FY 1993. The cost information shall be derived from the costs reported in the FY 1993 RSC-403 cost report. Allowable costs include only those costs incurred or to be incurred in the provision of hospital care and services, supplies and accommodations and determined in accordance with the Principles of Reimbursement For Provider Costs under 42 U.S.C. ss. 1395 et seq. as set forth in 42 CFR 413 et seq. and the Provider Reimbursement Manual, the HURM Manual and Generally Accepted Accounting Principles. For hospitals which converted a majority of beds to long-term care beds during FY 1993, the base year for Allowable Inpatient costs will be FY 1994 deflated to FY 1993, utilizing a FY 1993 - FY 1994 factor as calculated in Section of III. A. 2. d. (ii) (c) below.

a. Information submitted on the hospital's RSC-403 may be adjusted upon audit.

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b. If the specified data sources are unavailable or inadequate, payment rates will be determined using the best alternative data source and/or a statistical analysis will be performed to insure comparability of data.

2. Allowable Base Year Inpatient Operating Costs: Allowable Inpatient Base Year Operating Costs are the sum of Allowable Inpatient Direct Routine, Allowable Inpatient Direct Ancillary Costs, and Allowable Inpatient Overhead. The following is a description of each cost category.

a. Allowable Inpatient Direct Routine Costs are the hospital's reported inpatient routine costs, as adjusted by audit.

b. Allowable Inpatient Direct Ancillary Costs are determined for each ancillary cost center by multiplying the Total Direct Ancillary Costs for each cost center by the ratio of Inpatient Service Statistics to Total Patient Service Statistics. Then;

(i) Base Year costs for Laboratory, Radiology, Physical Therapy, Speech Therapy, Respiratory Therapy, and Occupational Therapy cost centers will be adjusted to incorporate efficiency standards. Efficiency standards are determined by ranking hospitals' unit costs and establishing median unit cost. The median unit cost will serve as the efficiency standard for each of these six (6) ancillary cost centers. Separate medians will be determined for Chronic Hospitals and Rehabilitation Hospitals. Hospitals will be classified as Chronic or Rehabilitation based on whether they provide primarily chronic (longer stay) or rehabilitation services as described in their FY 1994 RSC 420 submissions, and in the 1989 American Hospital Association Guide, and based on their average length of stay. In classifying hospitals for efficiency standards, respiratory and other longer stay specialty services shall be considered chronic rather than rehabilitation, and lengths of stay over 30 days shall indicate longer-stay service.

(ii) If the hospital's FY 1994 unit cost does not exceed the appropriate FY 1994 efficiency standard, its FY 1993 Direct Ancillary Costs will be allowed. If the hospital's FY 1994 unit costs exceed the efficiency standard, the FY 1993 Inpatient Direct Ancillary Cost for that cost center will be adjusted by a percentage which is derived from dividing the difference between FY 1994 unit cost and the efficiency standard by

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the FY 1994 units. The FY 1993 Direct Ancillary Costs for that cost center are reduced by this percentage.

(iii) For all other ancillary cost centers, the allowable cost will be the FY 1993 Inpatient Direct Ancillary Cost for that cost center as calculated in III.A. 2. b. of this plan amendment.

(iv) The sum of allowed costs for each ancillary cost center will be the Allowable Inpatient Direct Ancillary Costs.

c. Allowable Inpatient Overhead. Allowable Inpatient Overhead will be calculated by comparing Actual Inpatient Overhead to an efficiency standard. The efficiency standards are applied as follows:

(i) The sum of Base Year Inpatient Routine Overhead costs and Base year Inpatient Ancillary Costs will be divided by Base Year Patient Days to compute a hospital's Base Year Inpatient Overhead Per Diem Cost.

(ii) Inpatient Overhead Per Diems will be ranked by each Chronic Hospital and a median will be determined. The same procedure will be done for each Rehabilitation Hospital. The medians for each category of hospital will then serve as the efficiency standard.

(iii) If the hospital's Inpatient Overhead Per Diem cost does not exceed the appropriate efficiency standard, its Allowable Inpatient Overhead Costs will be its Actual Inpatient Overhead costs in c. (i) above. If the costs exceed the appropriate efficiency standard, the hospital's Allowable Inpatient Overhead Costs will be the efficiency standard multiplied by Base Year Patient Days.

d. Adjustments to Base Year Inpatient Operating Costs

(i) Substantial Program Change. For hospitals which have converted beds to long term care beds or discontinued major services between the base year and the rate year, base year costs shall be adjusted to remove the costs of the services no longer provided.

(ii) Inflation. Allowable Inpatient Direct Routine Cost Allowable Inpatient Direct Ancillary Costs, and Allowable Inpatient Overhead Costs will be adjusted for inflation from

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Base Year to Rate Year. These costs will be adjusted from fiscal year 1993 through fiscal year 1997 using a composite index comprised of two cost categories: Labor and Non-labor. These categories shall be weighed according to the weights used by the Health Care Financing Administration for PPS -exempt hospitals. The inflation proxy for the labor cost category shall be the Massachusetts Consumer Price Index. The inflation proxy for the Non-labor cost category will be the Non-labor portion of the HCFA market basket for hospitals.

- (a) The composite inflation index as calculated in accordance with the preceding paragraph will be increased by two percent (2%) pursuant to M.G.L. c.118G.
- (b) The DHCFP will recover the additional costs for which hospitals were reimbursed according to the provisions of 114.1 CMR 39.06(2)(b)4a see Appendix I, but were not expended on the compensation of technicians, nurses, nursing aides, orderlies and attendants, and occupational, speech, recreational, physical, and respiratory therapists, as required by M.G.L. c. 118G.
- (c) The inflation amounts are as follows:
 1993- 1994 Labor: 2.66%, Non-labor: 3.9%, 1994- 1995 Labor: 2.40%, Non-labor: 3.8%, 1995 - 1996 Labor 2.87%, Non-Labor 3.51%, and 1996-1997 Labor 2.22% Non-Labor 1.62% .

3. Allowable Capital: The hospital's allowable base year capital costs consist of the hospital's actual FY 1993 patient care capital requirement for historical depreciation for building and fixed equipment; reasonable interest expenses; amortization and; leases and rental of facilities. For hospitals which converted a majority of their beds to long-term care beds during FY 1993, allowable base year capital costs consist of the hospital's actual FY 1994 patient care capital requirement deflated to FY 1993 patient care requirement. Each facility's Allowable Inpatient Unit Capital Costs for FY 1997 shall be calculated as follows:

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- a. Base Year recognized capital cost is the hospital's actual capital cost subject to the limitations set forth in i. Allowable Capital Costs: Limitations section below.
- b. Base year Inpatient Capital cost equals actual total inpatient cost including capital less the base year actual total inpatient cost excluding capital.
- c. Base Year Routine Patient Days equal the hospital's reported days.
- d. Base Year Inpatient Unit Capital Cost equals the base year Inpatient Capital cost divided by the base year Routine Patient Days.
- e. FY 1997 Inpatient Unit Capital Cost equals the FY 1996 Hospital Unit Capital Cost multiplied by the HCFA Capital Update Factor for FY1996 to FY 1997 of 1%.
- f. The FY 1997 Inpatient Unit Capital will be ranked and a median will be determined which will serve as the efficiency standard.
- g. If the hospital's FY 1997 Inpatient Unit Capital Cost exceeds the efficiency standards, the Allowed Inpatient Unit Capital Cost will be the sum of the efficiency standard plus 20% of the amount which exceeds the standard.
- h. If the hospitals FY 1997 cost is below the efficiency standard the Allowed inpatient Unit Capital Cost will be the sum of its unit capital cost and 80% of the amount that is below the standard.
- i. Allowed Capital Costs: Limitations. The following are the limitations applied in the determination of allowable capital cost:
 - (i) Interest expense attributable to balloon payment on financed debt will not be allowed. Balloon payments are those in which the final payment on a partially amortized debt is scheduled to be larger than all preceding payments.
 - (ii) Where there has been a change of ownership after July 18, 1984, the allowable basis of the fixed assets to be used in the determination of the depreciation and interest expense shall be the lower of the acquisition cost of the new owner or the basis allowed for reimbursement purposes to the

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immediate prior owner. The allowed depreciation expense shall be calculated using the full useful lives of the assets.

(iii) All costs attributable to the negotiation or settlement of the sale or purchase of any capital asset after July 18, 1984, for which payment has been previously made by any payer, and which have been included in any portion of the prior years' rates, will be subtracted from allowable capital costs.

4. Calculation of Inpatient Per Diem Rate. The Inpatient Rate is calculated by dividing the sum of the hospital's Allowable Base Year Inpatient Operating costs including the Adjustments to Base Year Inpatient Operating costs, plus the hospital's Allowable Inpatient Capital by the hospital's Base Year Patient Days. The Inpatient Rate shall not exceed the hospital's average charge per day.

A supplementary payment is added to the initial rate of payment for all eligible services supplied by non-State-Owned Chronic/Rehabilitation Hospitals to publicly aided patients requiring hospital level of care. The supplementary payment is equal to the following:

Total Supplementary payment=

Inpatient Per Diem Rate - (\$113.27 x Total Number of FY 1997 Administrative Days)

No supplementary payment is given to a non-State-Owned Chronic/Rehabilitation Hospital where its Inpatient Rate for inpatient services provided to an administrative day patient is less than \$113.27, the per diem payment for an administrative day specified in Section III.A.7. below.

5. Administrative Adjustments to the Inpatient Per Diem Rate

a. A non-State-Owned Chronic/Rehabilitation Hospital may apply for a discretionary administrative adjustment to its Inpatient Per Diem Rate. In order for an adjustment to be made and/or considered the application must be filed within ninety (90) days of the rate approval.

b. In order to qualify for an adjustment the hospital must demonstrate that:

(i) the timing and amount of the increase in costs is reasonably certain; and

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